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HIPAA AND ITS RELATED LEGISLATION: A NEW ROLE FOR ERISA IN THE REGULATION OF PRIVATE HEALTH CARE PLANS?

COLLEEN E. MEDILL*

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The enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)¹ and its related legislation, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)² and the Mental Health Parity Act of 1996 (MHPA)³ (hereinafter collectively referred to as "HIPAA and its related legislation") signals a possible new role for the Employee Retirement Income Security Act of 1974 (ERISA),⁴ the federal law governing private health care plans.⁵ HIPAA and its related legislation

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1. Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 26 U.S.C.A., 29 U.S.C.A., & 42 U.S.C.A.).

2. Pub. L. No. 104-204, 110 Stat. 2935 (codified in scattered sections of 29 U.S.C.A. & 42 U.S.C.A.).

3. Pub. L. No. 104-204, 110 Stat. 2944 (codified in scattered sections of 29 U.S.C.A. & 42 U.S.C.A.).

4. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. & 29 U.S.C.).

5. Employee benefit plans subject to Title I of ERISA consist of employee welfare

represent a broadening, in the private health care context, of ERISA's Title I protective provisions from disclosure and fiduciary administration requirements to substantive benefit and coverage requirements in targeted areas. HIPAA and its related legislation also potentially signal a new approach by Congress to the issue of ERISA preemption of state insurance laws in the private health care plan context for those targeted areas where Congress has created new federal requirements. These changes may foreshadow a new willingness by Congress to use ERISA increasingly in the future to establish and enforce minimum federal standards, in targeted areas, for private health care plan coverage and benefits.

As evidenced by the variety of topics addressed in this symposium issue, there are numerous facets to reform of the health care system in the United States. Although a global answer to the issue of health care reform is elusive, one thing is clear: ERISA, long identified by scholars and politicians as a primary source of the health care "problem," must also be part of "the solution." Approximately sixty percent (estimates vary) of Americans under the age of sixty-five receive their health care coverage through their employment.⁶ The failure of the Clinton Administration's ambitious health care reform initiative indicates that this employment-based health care system is likely to remain intact as America moves into the next century. To the extent health care coverage is regulated by federal law, Title I of ERISA is the federal statute primarily responsible for regulating employment-based health care plans. Thus, one legislatively convenient way for Congress to enact targeted health care reforms in the future for a significant percentage of the United States population is to incorporate these reforms into ERISA's Title I requirements for private health care plans.

Part I of this article provides a brief review of the original legislative reform objectives underlying the enactment of ERISA in 1974. The overview discusses how the perceived abuses initially targeted by Title I's protective provisions related primarily to pension plans, not welfare plans.

benefit plans (welfare plans) and employee pension benefit plans (pension plans). See 29 U.S.C. § 1002(3) (1994). In ERISA parlance, health care plans are a type of welfare plan. See *id.* § 1002(1). Title I of ERISA governs any welfare plan that is established or maintained by any employer and/or employee organization representing employees. See *id.* § 1003(a). Title I of ERISA generally excludes plans established for the employees of churches or plans established for the employees of federal, state, and local governments or agencies. See *id.* §§ 1002(32) (defining governmental plans), 1002(33) (defining church plans), 1003 (defining general coverage of ERISA). The term "private health care plan" is used in this article to connote employment-based health care plans subject to Title I of ERISA.

6. See S. REP. NO. 104-156, at 3 (1995) (estimating that 61% of Americans receive their health care through their employment); CELIA SILVERMAN ET AL., EBRI DATABOOK ON EMPLOYEE BENEFITS 238 (3d ed. 1995) (estimating that 57% of Americans receive their health care through their employment).

As a result, Title I of ERISA, as originally enacted, contained numerous substantive coverage and benefits requirements for pension plans, but lacked similar substantive coverage and benefits requirements for private health care plans. Part I also illustrates the significance today of the dichotomy created in 1974 between "insured" and "self-insured" private health care plans by ERISA's preemption provisions with respect to state insurance law mandated benefits.

Part II of this article opens with a review of the amendments to Title I of ERISA enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)⁷ and the Omnibus Budget Reconciliation Act of 1993 (OBRA).⁸ The COBRA and OBRA amendments to ERISA established the first Title I coverage and benefits requirements for private health care plans in targeted areas. Against this background, the remainder of Part II analyzes the changes made to Title I of ERISA by HIPAA and its related legislation. Part II concludes that these changes may foreshadow a new role for ERISA in the regulation of private health care plans. This possible new role appears to have two related implications for health care reform in the future. First, Congress is likely to continue to establish substantive federal coverage and benefits requirements for private health care plans in targeted areas through Title I of ERISA. Second, in areas where federal requirements have been established for private health care plans, ERISA's preemption provisions are likely to operate as a "floor," preempting lesser state law requirements for insured private health care plans while preserving state law requirements for insured plans that offer greater benefits and protections to plan participants.

Finally, in keeping with the theme of this symposium issue, Part III of this article concludes with the identification of some of the emerging issues raised by this new role for ERISA in the regulation of private health care plans.

I. ERISA'S ORIGINAL LEGISLATIVE REFORM OBJECTIVES⁹

As originally enacted in 1974, Title I of ERISA established extensive substantive requirements for pension plan coverage and benefits.¹⁰ In con-

7. Pub. L. No. 99-272, § 10002(a), 100 Stat. 227, 227-31 (codified at 29 U.S.C. §§ 1161-1168 (1994)).

8. Pub. L. No. 103-66, § 4301, 107 Stat. 312, 371 (1993) (codified at 29 U.S.C. § 1169 (1994)).

9. Due to page limitations, the discussion below relies heavily on the conventional historical view of ERISA presented in chapter 1 of the American Bar Association's one-volume treatise on ERISA, AMERICAN BAR ASSOCIATION, EMPLOYEE BENEFITS LAW (1991) [hereinafter EMPLOYEE BENEFITS LAW], and the House and Senate Reports accompanying ERISA, *see infra* note 13.

10. *See infra* notes 28-31, 40-46 and accompanying text.

trast, Title I's requirements for private health care plans were limited to the selected areas of informational disclosures to plan participants, fiduciary conduct, and remedies for plan participants.¹¹ Title I initially did not establish substantive federal requirements for private health care plan coverage and benefits.¹²

A. *Pre-ERISA Reform Attempts*

ERISA's regulation of both private health care plans and pension plans under a single set of common rules in Title I appears to have been much more the product of a common history of perceived abuses rather than of a commonality of plan purpose, design, and function. In the post-World War II United States economy, private employers increasingly began to offer their employees retirement and health care benefits.¹³ As industries became unionized and employee benefits became a mandatory subject of collective bargaining,¹⁴ labor unions established retirement and health care trust funds to provide pension and health care benefits to union members.¹⁵ As these union funds grew in size, so did concerns that the fund assets presented opportunities for abuse by plan fiduciaries.¹⁶

These concerns arose in part because the funds were administered by union officials without any legal obligation to account to either the contributing employers or the union membership.¹⁷ In response to this concern, Congress enacted section 302 of the Labor Management Relations Act of 1947 (LMRA or Taft-Hartley Act).¹⁸ Section 302 of the LMRA required that such union-sponsored Taft-Hartley Act plans be administered by a joint board of trustees comprised of an equal number of management and labor representatives.¹⁹ Federal judicial decisions involving the conduct of Taft-Hartley Act plan trustees began to develop a caselaw-driven body of

11. See *infra* notes 28-37 and accompanying text.

12. See Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. & 29 U.S.C.).

13. See H.R. REP. NO. 93-533, at 2 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4640; S. REP. NO. 93-127, at 3 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4839; EMPLOYEE BENEFITS LAW, *supra* note 9, at 3.

14. See *Inland Steel Co. v. NLRB*, 170 F.2d 247 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949) (holding that employee benefit plans were terms and conditions of employment subject to collective bargaining).

15. See EMPLOYEE BENEFITS LAW, *supra* note 9, at 3.

16. See *id.* at 4 & n.14.

17. See *id.*

18. Pub. L. No. 80-101, 61 Stat. 136 (codified at 29 U.S.C. §§ 141-187 (1994)).

19. 29 U.S.C. § 186(c)(5) (1994).

fiduciary principles for plan administration and the investment of plan assets.²⁰

As both pension and health care plans continued to grow in popularity and size, it became evident that employees participating in such plans needed additional federal protections. In response, Congress enacted the Welfare and Pension Plans Disclosure Act of 1958 (WPPDA).²¹ The WPPDA required plan administrators to provide certain informational disclosures to plan participants in the congressional hope that, armed with such information, plan participants could effectively police the administration of their own plans.²² Congress strengthened the WPPDA in 1962 by making theft, bribery, embezzlement, or kickbacks involving plan assets federal crimes, and by giving the Secretary of Labor limited regulatory and investigatory powers over employee benefit plans.²³

Both section 302 of the LMRA and the WPPDA proved ineffective in curbing the abuse of plan assets by plan fiduciaries. Both laws failed to establish fiduciary standards and civil liability for misconduct that did not rise to a criminal level.²⁴ A related area of needed reform common to both pension and health care plans, which was not addressed by either the LMRA or the WPPDA, was the elimination of substantive and procedural obstacles faced by plan participants seeking to enforce their rights in court.²⁵ When rights and remedies developed under the common law of trusts proved ineffective in the employee benefit plan context, various states began to enact their own laws regulating employee benefit plans.²⁶ The enactment of these state laws led to concerns by some employers that their employee benefit plans, which provided benefits to employees in multiple states, could be subject to compliance under conflicting and inconsistent state laws.²⁷

20. See EMPLOYEE BENEFITS LAW, *supra* note 9, at 4 & n.18.

21. Pub. L. No. 85-836, 72 Stat. 997 (1958) (codified at 29 U.S.C. §§ 303-309 (1976)), *repealed by* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 111(a)(1), 88 Stat. 829, 851.

22. See H.R. REP. No. 93-533, at 4 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4641 (discussing failures of the WPPDA); S. REP. No. 93-127, at 4 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4840-41 (discussing failures of the WPPDA).

23. See 29 U.S.C. §§ 305-308 (1976), *repealed by* Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 111(a)(1), 88 Stat. 829, 851.

24. See H.R. REP. No. 93-533, at 4, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4642; S. REP. No. 93-127, at 4 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4841.

25. See H.R. REP. No. 93-533, at 17 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655; S. REP. No. 93-127, at 35 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871.

26. See EMPLOYEE BENEFITS LAW, *supra* note 9, at 5.

27. *Id.* at 5 & n.23.

B. Original ERISA Title I Reforms

Congress enacted Title I of ERISA in part to address needed reforms in the areas of plan disclosure, fiduciary responsibility, and enforcement of participants' rights.²⁸ As enacted in 1974, Title I contained five parts, each addressing an area in need of reform.²⁹ Of these five, parts 1, 4, and 5 apply to both welfare and pension plans.³⁰ Parts 2 and 3 apply only to pension plans.³¹

Part 1 of Title I established requirements for annual reporting to the government and informational disclosures to plan participants.³² These requirements were more rigorous than the disclosure requirements of the WPPDA, which were repealed.³³ Part 4 established standards for plan documentation, the handling of plan assets, and civil liability standards for fiduciary conduct.³⁴ These standards drew upon fiduciary standards developed under the common law of trusts, but with certain modifications appropriate for employee benefit plans.³⁵ Part 4 also prohibited certain types of transactions involving plan assets and allowed for certain exemptions from these prohibited transaction rules.³⁶ Part 5 provided for criminal penalties, private civil remedies, and federal court jurisdiction for civil enforcement actions by plan participants, beneficiaries, fiduciaries, or the Secretary of Labor.³⁷ The creation of private causes of action under ERISA and federal court jurisdiction over such civil actions resolved the substantive and procedural obstacles faced by plan participants in the courts. Part 5 also contained ERISA's now controversial preemption provisions,³⁸ which Congress intended to ensure national uniformity in the regulation of employee benefit plans.³⁹

28. See 29 U.S.C. § 1001 (1994).

29. See *id.* §§ 1021-1144.

30. See *id.* §§ 1021-1030 (part 1), 1101 (coverage of part 4), 1131-1144 (part 5).

31. See *id.* §§ 1051(1) (excluding welfare benefit plans from part 2 of ERISA), 1081(1) (excluding welfare benefit plans from part 3 of ERISA).

32. See *id.* §§ 1021-1030.

33. See *id.* § 1031(a)(1).

34. See *id.* §§ 1102-1105, 1109-1112.

35. See H.R. REP. NO. 93-533, at 11-13 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4649-51; S. REP. NO. 93-127, at 30 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4866.

36. 29 U.S.C. §§ 1106-1108.

37. See *id.* §§ 1131-1132.

38. See *id.* § 1144. Exemptions to ERISA's preemption of state laws were later added for the Hawaii Prepaid Health Care Act, *id.* § 1144(b)(5), multiple employer welfare arrangements, *id.* § 1144(b)(6), and qualified domestic relations orders and qualified medical child support orders, *id.* § 1144(b)(7).

39. See H.R. REP. NO. 93-533, at 17 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639,

Title I of ERISA also contained detailed provisions regulating the coverage and benefits of pension plans.⁴⁰ Part 2 of Title I established minimum standards for employee participation in pension plans,⁴¹ minimum standards for the vesting of plan benefits,⁴² standards for the accrual and cutback of pension plan benefits,⁴³ standards for the form of benefit payments,⁴⁴ and rules governing plan mergers and asset transfers.⁴⁵ Part 3 of Title I established minimum funding requirements for defined benefit pension plans.⁴⁶ Congress enacted these extensive requirements in response to well-publicized accounts of employees with long years of service failing to vest in their pension plan benefits and employees not being paid their full pension plan benefits due to inadequate funding of employers' plans.⁴⁷

In contrast to these extensive requirements governing the coverage and benefits of pension plans, Title I of ERISA, as initially enacted, did not contain a single substantive coverage or benefit requirement for private health care plans. This complete absence of federal regulation provides a baseline from which to evaluate the significance of subsequent congressional attempts, described in Part II of this article, to regulate the coverage and benefits provided by private health care plans through Title I of ERISA.

C. "Insured" Versus "Self-Insured" Private Health Care Plans

One consequence of ERISA's Title I preemption provisions, as interpreted and applied by the Supreme Court in *Metropolitan Life Insurance Co. v. Massachusetts*⁴⁸ and in *FMC Corp. v. Holiday*,⁴⁹ was the de facto creation of two categories of private health care plans under ERISA. "Insured" health care plans provide health care benefits to plan

4647-48; S. REP. NO. 93-127, at 35 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4851.

40. Other requirements regulating the coverage and benefits for tax-qualified pension plans are found in part 400 of the Internal Revenue Code. See generally 26 U.S.C. §§ 401-417 (1994). ERISA and the Internal Revenue Code contain many overlapping requirements in the pension plan area.

41. See 29 U.S.C. § 1052 (1994).

42. See *id.* § 1053.

43. See *id.* § 1054.

44. See *id.* §§ 1055-1056.

45. See *id.* § 1058.

46. See *id.* §§ 1081-1085.

47. See H.R. REP. NO. 93-533, at 5 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4644; S. REP. NO. 93-127, at 5 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4845; EMPLOYEE BENEFITS LAW, *supra* note 9, at 6.

48. 471 U.S. 724 (1985).

49. 498 U.S. 52 (1990).

participants through the purchase of health care insurance.⁵⁰ Because ERISA does not preempt state laws regulating insurance, insurance companies selling health care insurance policies (and, thus, indirectly the policy benefits to plan participants) are subject to regulation by state insurance laws.⁵¹ In particular, state insurance laws mandate and regulate the types of benefits that must be included in health insurance policies.⁵²

"Self-insured" or "self-funded" health care plans provide health care benefits to plan participants from a fund comprised of employer or employee contributions, or both, or out of the general assets of the employer.⁵³ State laws attempting to regulate employee health care plans as "insurance" are preempted by ERISA and, therefore, do not apply to self-insured health care plans.⁵⁴ The preemption of state laws with respect to self-insured private health care plans has been criticized often in the scholarly literature.⁵⁵ Specifically, critics have argued that, due to ERISA's lack of substantive coverage and benefits requirements for private health care plans, such preemption in effect allows self-insured plans to operate in a regulatory void.⁵⁶

Although insured and self-insured plans are easily distinguishable in theory, in recent years the line between them, and thus the threshold for state regulation, has become increasingly blurred. To protect against the risk of catastrophic health care claims, typically self-insured plans purchase so-called "stop-loss" insurance.⁵⁷ Stop-loss insurance insures the plan against claims above a certain dollar amount.⁵⁸ This dollar amount is

50. *Id.* at 52-53.

51. See 29 U.S.C. § 1144(b)(2)(A) (1994) (savings clause); *Metropolitan Life Ins. Co.*, 471 U.S. at 746-47.

52. See *Metropolitan Life Ins. Co.*, 471 U.S. at 746.

53. See EMPLOYEE BENEFITS LAW, *supra* note 9, at 1050-52.

54. See 29 U.S.C. § 1144(b)(2)(B) (deemer clause); *FMC Corp.*, 498 U.S. at 61.

55. See, e.g., Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 37 n.5 (1996); James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 437-38 (1994); Alan I. Widiss & Larry Gostin, *What's Wrong with the ERISA "Vacuum"? The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage Is to Be Provided When Risk Retention Plans Are Established for Health Care*, 41 DRAKE L. REV. 635, 638-44 (1992).

56. See sources cited *supra* note 55.

57. See EMPLOYEE BENEFITS LAW, *supra* note 9, at 1051-52; Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 626 (1995).

58. EMPLOYEE BENEFITS LAW, *supra* note 9, at 1052 & n.619; Groves, *supra* note

known as the "attachment point."⁵⁹ As attachment points have declined, self-insured plans, in the eyes of state insurance commissioners, have begun to resemble insured plans potentially subject to state regulation.⁶⁰

Stop-loss insurance was at the heart of the issue in *American Medical Security, Inc. v. Bartlett (AMS)*,⁶¹ a recent Fourth Circuit case. The technical issue before the federal court of appeals in *AMS* was whether ERISA preempted a Maryland insurance regulation aimed at stop-loss insurance policies.⁶² The regulation provided that any stop-loss insurance policy with an attachment point of less than \$10,000 in benefits paid for an individual would be considered a health insurance policy and subject to twenty-eight various types of health care benefits mandated by Maryland insurance law.⁶³ The Maryland Insurance Commissioner unsuccessfully argued that if the regulation was preempted by ERISA, a loophole would exist so that every self-insured health care plan could provide fewer and lesser benefits than the twenty-eight benefits mandated by Maryland insurance law.⁶⁴ Upon finding that "at bottom, state insurance regulation may not directly or indirectly regulate self-funded ERISA plans,"⁶⁵ the Fourth Circuit ruled that "[i]n seeking to require self-funded plans to offer coverage consistent with state insurance law, Maryland cross[ed] the line of [ERISA] preemption."⁶⁶ As a result, the "self-insured" plan was not subject to the twenty-eight benefits mandated by Maryland insurance law for "insured" health care plans.⁶⁷

AMS dramatically illustrates the significance today of the dichotomy created by Title I's preemption provisions between insured and self-insured private health care plans. As *AMS* aptly demonstrates, ERISA preemption of state insurance laws with respect to self-insured private health care plans gives plan sponsors a strong incentive to self-insure and thereby avoid benefits mandated by state insurance law for insured plans.

57, at 626 & n.94

59. See *American Med. Sec., Inc. v. Bartlett*, 111 F.3d 358, 360 (4th Cir. 1997) (offering one definition of an attachment point by example).

60. See *id.* at 361.

61. 111 F.3d 358 (4th Cir. 1997).

62. *Id.* at 359-60.

63. *Id.* at 360.

64. *Id.* at 362.

65. *Id.* at 361.

66. *Id.* at 363-64.

67. *Id.* at 364-65.

II. FEDERAL STANDARDS FOR PRIVATE HEALTH CARE PLAN COVERAGE AND BENEFITS UNDER ERISA

A. COBRA and OBRA

Congress enacted the first substantive federal requirements for private health care plans under Title I of ERISA as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).⁶⁸ Eight years later, additional Title I federal requirements for private health care plans were created as part of the Omnibus Budget Reconciliation Act of 1993 (OBRA).⁶⁹ These two amendments to Title I are noteworthy as initial congressional attempts to implement the first substantive federal coverage and benefits requirements for private health care plans through ERISA.

COBRA, which became part 6 of Title I, requires that a sponsor of a group health plan⁷⁰ provide each qualified beneficiary,⁷¹ who otherwise would lose coverage under the plan due to the occurrence of a qualifying event,⁷² the opportunity to continue coverage under the plan.⁷³ The maximum period of continuation coverage varies from eighteen to thirty-six months, depending upon the type of qualifying event that triggers COBRA rights.⁷⁴ Failure to comply with COBRA's requirements potentially subjects the employer (or, in the case of a multi-employer plan, the plan itself) to a tax penalty of \$100 per day, per qualified beneficiary.⁷⁵ COBRA continuation coverage is not free to the qualified beneficiary, who may be required by the plan sponsor to pay up to 102% of the applicable

68. Pub. L. No. 99-272, § 10002(a), 100 Stat. 227, 227-31 (1986) (codified at 29 U.S.C. §§ 1161-1168 (1994)).

69. Pub. L. No. 103-66, § 4301(a), 107 Stat. 371, 371-75 (1993) (codified at 29 U.S.C. § 1169 (1994)).

70. Group health plans subject to COBRA include both insured and self-insured private health care plans. *See* 29 U.S.C. § 1167(1) (1994). Plans with fewer than 20 employees are exempt from COBRA, *see id.* § 1161(b), but insured plans with fewer than 20 employees may still be subject to state insurance law COBRA-type requirements.

71. Qualified beneficiaries can include the employee, the employee's spouse, and any dependent children covered under the plan. *See id.* § 1167(3).

72. Qualifying events include the death of the covered employee, the termination or reduction in hours of the covered employee's employment, the divorce of the covered employee, the covered employee's entitlement to Medicare benefits, or a dependent child ceasing to meet the requirements for coverage as a dependent child under the terms of the plan. *See id.* § 1163.

73. *See id.* § 1161(a).

74. *See id.* § 1162.

75. *See* 26 U.S.C. § 4980B(b)(1) (1994). Minimum and maximum penalty limits may also apply. *See id.* § 4980B(b)(3)-(c).

premium.⁷⁶ Thus, COBRA may be viewed as creating a limited federal coverage mandate for those employees who are able to afford the cost of COBRA coverage premiums.⁷⁷

OBRA added an additional section to part 6 of Title I that created three new requirements related to benefits for children.⁷⁸ First, OBRA provided for an exception to ERISA preemption to permit the enforcement of qualified medical child support orders.⁷⁹ Second, OBRA required that private health care plans must provide coverage and benefits for adopted children of plan participants on the same terms and conditions as coverage for children born to plan participants.⁸⁰ Third, OBRA prohibited private health care plans from reducing coverage of pediatric vaccine costs below the coverage level provided under the plan as of May 1, 1993.⁸¹

In retrospect, the amendments to Title I made by COBRA and OBRA are interesting in that they represent two possible approaches to financing health care reforms enacted through ERISA. Under the COBRA approach, the employer must offer the required Title I benefits only if the employee pays for them.⁸² Moreover, the entire cost of these Title I benefits is born solely by the individual employee seeking the benefits and is not allocated among all of the plan participants.⁸³ Under the OBRA approach, if the plan sponsor chooses to have a health care plan, the plan must contain certain Title I required benefits.⁸⁴ The plan sponsor (typically the employer) can decide whether to absorb the additional cost of the required Title I benefits or to allocate part or all of the additional costs to the participants in the plan. As discussed below, HIPAA and its related legislation appear

76. See 29 U.S.C. § 1162(3)(A) (1994).

77. Congress recognized the difficulty unemployed persons may have in paying for COBRA continuation coverage. Accordingly, effective January 1, 1997, HIPAA amended the Internal Revenue Code to eliminate the 10% penalty on distributions from an individual retirement account or annuity (IRA) before age 59 1/2 for persons who had received unemployment compensation for twelve consecutive weeks. This exception applies only if the IRA distributions are used to pay health insurance premiums, including COBRA premiums. See Pub. L. No. 104-191, § 361, 110 Stat. 2071, 2071-72 (1996); H.R. CONF. REP. NO. 104-736, at 313-14 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, 2126-27.

78. See 29 U.S.C. § 1169 (1994).

79. See *id.* §§ 1144(b)(7), 1169(a). A qualified medical child support order is any judgment, decree, order, or settlement agreement which is made pursuant to a state domestic relations law or which enforces a state medical child support law under the federal Medicaid rules, and which requires a private health care plan to provide coverage to the child of a plan participant. See *id.* § 1169(a)(2)(A)-(B).

80. See *id.* § 1169(c).

81. See *id.* § 1169(d).

82. See *id.* § 1162(3).

83. See *id.*

84. See *id.* § 1169.

to reject the COBRA financing approach and instead follow the OBRA approach.

B. Health Insurance Portability and Accountability Act

Prior to the enactment of HIPAA and its related legislation, Congress made several attempts at health care reform during the 1990s, all without success.⁸⁵ In the absence of congressional action on health care reform, the states stepped to the forefront by enacting laws aimed at "reforming the health care insurance market."⁸⁶ The state laws particularly targeted the health insurance market for small employers.⁸⁷ However, these state-level insurance law reform efforts were of limited effectiveness for several reasons. First and foremost, these reforms applied only to insured health care plans as a result of ERISA's preemption provisions, which exempted self-insured plans from state insurance law reform efforts.⁸⁸ Because approximately forty to fifty percent of the United States population with private health care insurance coverage obtained coverage through a self-insured health care plan, preemption of state law was a significant obstacle to reform.⁸⁹ Moreover, the trend toward self-insurance was growing.⁹⁰ In 1993, sixty-three percent of employers with five hundred or more employees had self-insured health care plans, whereas by 1994 this percentage had increased to seventy-four percent.⁹¹ Furthermore, as the attachment points on stop-loss insurance policies continued to decline, states had increasing difficulty determining whether a particular plan was insured or self-insured.⁹²

Another significant limitation on the effectiveness of state-level reforms was (and still is) inherent in a federal system of government. State insurance law reforms applicable in Maine did not apply when an employee moved or was transferred by his or her employer to Minnesota or Missouri. This limitation dove-tailed with another significant issue: the perceived problem of health care "job-lock" and the need for nationwide "portability" of health care coverage.⁹³ Health insurance companies and self-insured

85. See S. REP. NO. 104-156, at 9 (1995).

86. See *id.*

87. See *id.*

88. See *id.* at 9-10.

89. See *id.* at 5 & n.7 (citing Congressional Research Service Report). The General Accounting Office has estimated a much lower figure—27% of the U.S. population—as receiving health care coverage through ERISA self-funded plans. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,915 (1997).

90. See *id.* at 5 & n.5 (citing General Accounting Office Report).

91. See *id.* at 5 (citing Employee Benefits Research Institute data).

92. See *id.* at 6 & n.9 (citing General Accounting Office Report).

93. See *id.* at 8; Interim Rules for Health Insurance Portability for Group Health

plans often restricted or excluded plan coverage for the treatment of health conditions that existed prior to the time the participant enrolled in the plan (pre-existing conditions).⁹⁴ These coverage limitations for pre-existing conditions were designed to prevent the practice of "adverse selection," whereby persons tend to wait until they become ill before obtaining health care coverage.⁹⁵ According to one Senate report, "an estimated eighty-one million Americans suffer from some type of preexisting medical condition that could make it difficult for them to obtain health coverage, especially for [their pre-existing] condition[s]," if they changed to a different health plan.⁹⁶ As of mid-1996, forty-four states had enacted laws limiting the duration of pre-existing condition coverage exclusions for insured private health care plans.⁹⁷ These laws did not, however, apply to self-insured private health care plans by virtue of ERISA preemption.⁹⁸

To address these issues at the federal level, Congress enacted HIPAA.⁹⁹ HIPAA amended ERISA by adding a new part 7 to Title I of the statute.¹⁰⁰ Part 7 limits the ability of private health care plans to impose pre-existing condition coverage exclusions on plan participants.¹⁰¹ These new federal requirements, which are effective for plan years beginning after June 30, 1997,¹⁰² apply to any private health care plan with at least two participants who are current employees.¹⁰³

Plans, 62 Fed. Reg. at 16,910.

94. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. at 16,908 (citing Bureau of Labor Statistics indicating that for 1993-1994, 46% of participants in private sector, employer-sponsored health plans were subject to pre-existing condition coverage exclusions).

95. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 731 (1985).

96. See S. REP. NO. 104-156, at 3.

97. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. at 16,914-15. In addition, "thirty states had time limits on pre-existing condition exclusion periods that are the same as or more favorable to individuals than the HIPAA provisions for the group market." *Id.*

98. See 29 U.S.C. § 1144(b)(2)(B) (1994).

99. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 26 U.S.C.A., 29 U.S.C.A., & 42 U.S.C.A.). HIPAA also addresses numerous other health care reform issues that are beyond the scope of this article, such as reforms of the group and individual health insurance markets to guarantee availability and renewability of health insurance coverage, technical amendments to COBRA, Medicare and Medicaid fraud and abuse, medical savings accounts, and long-term care insurance. *Id.*

100. *Id.* § 101, 110 Stat. at 1939-55 (codified at 29 U.S.C.A. §§ 1181-1183, 1191-1191c (West, Supp. 1997))

101. 29 U.S.C.A. § 1181(a) (West Supp. 1997).

102. *Id.* § 1181(g)(1).

103. *Id.* § 1191(a).

HIPAA provides that a group health plan¹⁰⁴ or a health insurance issuer offering group health insurance coverage¹⁰⁵ may impose a coverage exclusion for a pre-existing health condition of a plan participant or beneficiary only under the following circumstances:

- (1) the exclusion must relate to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six month period ending on the participant's enrollment date in the plan;¹⁰⁶ and
- (2) the period of the coverage exclusion must not be more than twelve months;¹⁰⁷ and
- (3) the period of the coverage exclusion must be reduced by the aggregate period of prior creditable coverage.¹⁰⁸

104. A group health plan is defined as "any employee welfare benefit plan . . . provid[ing] medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement or otherwise." *Id.* § 1191(a)(1). Thus, both insured and self-insured private health care plans are subject to HIPAA's requirements.

105. A health insurance issuer is defined to include health maintenance organizations (HMOs). *See id.* § 1191(b)(2).

106. *See id.* § 1181(a)(1).

107. *See id.* § 1181(a)(2). This twelve month period extends to a maximum of eighteen months for "late enrollees." *Id.* A late enrollee is a plan participant or beneficiary who fails to enroll in the plan during the first period he or she is eligible to enroll or during a special enrollment period. *See id.*

108. *See id.* § 1181(a)(3). Special rules apply to HMOs limiting the use of an "affiliation period" in lieu of the pre-existing condition coverage exclusions. *See id.* § 1181(g). Certain benefits, defined as "excepted benefits," are excluded from HIPAA's requirements. *See id.* § 1191a(b). Excepted benefits include:

- (A) Coverage only for accident, or disability income insurance.
- (B) Coverage issued as a supplement to liability insurance.
- (C) Liability insurance, including general insurance liability and automobile liability insurance.
- (D) Workers' compensation or similar insurance.
- (E) Automobile medical payment insurance.
- (F) Credit-only insurance.
- (G) Coverage for on-site medical clinics.

Id. § 1191b(c)(1). Limited scope dental or vision benefits and benefits for long term care, nursing home care, home health care, and community-based care are excluded from HIPAA's requirements if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan. *See id.* § 1191a(c)(2). Similarly, separate coverage is also excluded from HIPAA's requirements for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, and Medicare supplemental insurance. *See id.* §§ 1191a(c)(2)-(3), 1191b(c)(3)-(4).

The key to HIPAA's coverage portability is the reduction of the period of the plan's pre-existing condition coverage exclusion by the participant's prior creditable coverage.¹⁰⁹ Creditable coverage is defined broadly by HIPAA as almost any type of health care coverage, such as coverage through a private employer, federal or state government group health plan, individual health insurance, COBRA coverage, Medicare and Medicaid coverage, the military, the Indian Health Service, or the Peace Corps.¹¹⁰ An individual's prior creditable coverage is forfeited, however, if the participant has a period of sixty-three or more days during which the individual does not have any one of the enumerated types of creditable coverage.¹¹¹ Thus, if an individual has at least twelve months of prior health care coverage, enrolls in the subsequent plan at the first opportunity, and has not experienced a sixty-three consecutive¹¹² day lapse in coverage, the plan effectively is prohibited from imposing any pre-existing condition coverage exclusions.¹¹³

In addition to the limitations on the plan's ability to impose pre-existing condition coverage exclusions, HIPAA prohibits the imposition of pre-existing condition coverage exclusions, irrespective of the individual's lack of prior creditable coverage, in the following circumstances:

- (1) newborn children enrolled in the plan within thirty days of birth;¹¹⁴
- (2) adopted children under age eighteen enrolled in the plan within thirty days of adoption or placement for adoption;¹¹⁵ and
- (3) any condition relating to pregnancy.¹¹⁶

HIPAA also prohibits group health plans and issuers of group health insurance from basing health care coverage eligibility on any of the following health-related factors of the individual or a dependent of the individual:

- (1) Health status.
- (2) Medical condition (including both physical and mental illness).
- (3) Claims experience.
- (4) Receipt of health care.

109. See *id.* § 1181(a).

110. See *id.* § 1181(c)(1).

111. See *id.* § 1181(c)(2)(a). The period of time during which an individual is in a waiting period for eligibility to enroll in the plan (or, for an HMO, an affiliation period) is not counted toward the sixty-three consecutive-day absence of coverage forfeiture rule. See *id.* § 1181(c)(2)(b).

112. See 29 C.F.R. § 2590.701-4(b)(2)(iii) (1997) (defining a significant break in coverage as "a period of 63 consecutive days during all of which the individual does not have any creditable coverage" (excluding waiting and affiliated periods)) (emphasis added).

113. See 29 U.S.C.A. § 1181(a).

114. See *id.* § 1181(d)(1).

115. See *id.* § 1181(d)(2).

116. See *id.* § 1181(d)(3).

- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability¹¹⁷ (including conditions arising out of acts of domestic violence).
- (8) Disability.¹¹⁸

HIPAA further prohibits group health plans and issuers of group health plan insurance from charging an individual more than similarly situated individuals for coverage based on any of these health-related factors.¹¹⁹ HIPAA does not, however, require a group health plan to provide particular benefits,¹²⁰ and it allows a group health plan to establish limits or place restrictions on the amount, level, extent, or nature of the plan's coverage or benefits for "similarly situated"¹²¹ individuals enrolled in the plan.¹²² Nor does HIPAA restrict the premium amount a plan may charge to *all* participants in the group health plan.¹²³

HIPAA's requirements are generally made enforceable against private health care plans through a COBRA-type tax penalty of potentially \$100 per day, per individual affected, for failure to comply.¹²⁴ Minimum and

117. The "inclusion of evidence of insurability in the definition of health status is intended to ensure . . . that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities." H.R. CONF. REP. NO. 104-736, at 186 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, 1999.

118. *See* 29 U.S.C.A. § 1182(a)(1)(A)-(H).

119. *See id.* § 1182(b)(1). Premium discounts, rebates, or reductions in co-payment or deductible amounts are still permitted for participation in narrowly defined "bona fide wellness programs." *See id.* § 1182(b)(2)(B); Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,938-39 (1997) (to be codified at 26 C.F.R. § 54.9802-1T) (temporary regulations).

120. *See* 29 U.S.C.A. § 1182(a)(2)(A).

121. The Conference Report accompanying HIPAA states that "[t]he term 'similarly situated' means that a plan or coverage would be permitted to vary benefits available to different groups of employees, such as full-time versus part-time employees or employees in different geographic locations. In addition, a plan or coverage could have different benefit schedules for different . . . bargaining units." *See* H.R. CONF. REP. NO. 104-736, at 187 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, 2000.

122. *See* 29 U.S.C.A. § 1182(a)(2)(B).

123. *See id.* § 1182(b)(2)(A).

124. *See* Pub. L. No. 104-191, § 402, 110 Stat. 2084 (1996) (adding new § 4980D to the Internal Revenue Code). Congress subsequently added similar COBRA-type tax penalties to the Code for violations of the Newborns' and Mothers' Health Protection Act, discussed *infra* Part II.D, and the Mental Health Parity Act, discussed *infra* Part II.E, both as part of the Taxpayer Relief Act of 1997. *See* Pub. L. No. 105-34, § 1531(a)(4), 111 Stat. 788, 1080-81 (1997) (adding new § 9811 and § 9812 to the Code).

maximum tax penalties apply in certain circumstances.¹²⁵ Pursuant to ERISA's civil enforcement provisions, individuals may bring a private cause of action to enforce the requirements of part 7.¹²⁶

Sections 701 and 702 of HIPAA necessarily operate in unison in a fashion analogous to the nondiscrimination provisions of the Internal Revenue Code for qualified pension plans.¹²⁷ Section 701(a) limits or, in some cases, eliminates the imposition of a pre-existing condition coverage exclusion upon a new plan participant.¹²⁸ In the absence of section 702(a)(1), a group health plan could, rather than admit an individual with a pre-existing condition (but with no pre-existing condition coverage exclusion) as a participant in the plan, simply declare the individual ineligible to participate in the plan due to the individual's pre-existing health condition. Section 702(a)(1) prevents such tactics by prohibiting a group health plan from basing eligibility on the enumerated health status related factors.¹²⁹ Finally, faced with the admission, by virtue of sections 701(a) and 702(a)(1), of a new plan participant with a pre-existing health condition (but no pre-existing condition coverage exclusion), a group health plan could discourage the new participant's enrollment in the plan by charging a prohibitively higher premium for that particular participant due to the foreseeable additional cost attributable to coverage and benefits for the pre-existing condition. Section 702(b)(1) likewise prevents such tactics by prohibiting the practice of charging a greater premium or contribution to an individual than to "similarly situated" individuals based upon a health status related factor.¹³⁰

Although the stated congressional intent in enacting HIPAA's provisions was to prohibit the knowing design of a group health plan to exclude

125. See 26 U.S.C.A. § 4980D (West Supp. 1997).

126. See H.R. CONF. REP. NO. 104-736, at 191 (1996), *reprinted in* 1996 U.S.C.C.A.-N. 1990, 2004; Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,896 (1997). Private enforcement actions by individual plan participants for failure to comply with HIPAA, NMHPA, or MHPA requirements would most likely be brought pursuant to ERISA section 502(a)(3) as an injunctive action to prohibit the plan from violating Title I requirements for private health care plans. See 29 U.S.C. § 1132(a)(3) (1994). The federal courts have exclusive jurisdiction over ERISA section 502(a)(3)-type claims. See *id.* § 1132(e)(1).

127. See JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 221-22 (2d ed. 1995) (discussing section 401(a)(4)'s provisions as a necessary corollary to section 401(b)'s coverage and participation requirements). Of course, unlike qualified pension plans, in the private health care plan context employers are free to "discriminate" in benefits provided to employees on the basis of job status, which is often closely associated with compensation. See, e.g., *supra* note 121.

128. See *supra* notes 104-16 and accompanying text.

129. See *supra* text accompanying notes 117-18.

130. See *supra* note 119.

individuals and their dependents,¹³¹ HIPAA does not prohibit a plan design or terms which are generally applicable to all plan participants, but which may have a disparate impact on individual enrollees due to the individual's need for more or specific benefits under the plan.¹³² The Conference Report accompanying HIPAA summarizes the intended effect of HIPAA's provisions as follows:

The conferees intend that these provisions preclude insurance companies from denying coverage to employers based on health status and related factors that they have traditionally used. In addition, this provision is meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums based on their health status and other related factors that could lead to higher health costs. This does not mean that an entire group cannot be charged more. But it does preclude health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether.¹³³

C. Preemption Under HIPAA

HIPAA signals a potential change in Congress's approach to ERISA's preemption provisions with respect to those targeted areas where Congress has acted to create federal coverage and benefits requirements. Although new ERISA section 731 purports to reaffirm, in part, the preemption status quo,¹³⁴ it specifically addresses and alters the preemption scheme for state insurance laws.¹³⁵ Section 731 provides that new ERISA part 7 is not to be construed to supercede state insurance law standards or requirements related solely to health insurance issuers in connection with group health insurance coverage, *except* to the extent that such state insurance law requirements prevent the application of one of part 7's requirements.¹³⁶ Thus, HIPAA's requirements preempt any related but inconsistent state law

131. See H.R. CONF. REP. NO. 104-736, at 186 (1996), *reprinted in* 1996 U.S.C.C.-A.N. 1990, 1999.

132. See *id.* Such plan design features having a disparate impact on certain individuals may, however, violate the Americans with Disabilities Act (ADA). See generally Interim Enforcement Guidance on the Application of the Americans with Disabilities Act of 1990 to Disability-Based Distinctions in Employer Provided Health Insurance, EEOC-N-915.002 (June 8, 1993), available in WESTLAW, ADA-TAM Database [hereinafter EEOC Interim Enforcement Guide].

133. See H.R. CONF. REP. NO. 104-736, at 187 (1996), *reprinted in* 1996 U.S.C.C.-A.N. 1990, 2000.

134. See 29 U.S.C.A. § 1191(a)(2) (West Supp. 1997) ("Nothing in this part [7] shall be construed to affect or modify the provisions of [ERISA section 514] . . . with respect to group health plans.").

135. See *id.* § 1191(a)(1)-(b).

136. See *id.* § 1191(a)(1).

standard or requirement, including state insurance laws.¹³⁷ State insurance laws regulating health insurance issuers are saved from ERISA preemption only if these laws are more favorable to plan participants than HIPAA's requirements.¹³⁸

HIPAA's preemption of less favorable state insurance law requirements may presage Congress's future approach to federal health care reform as it relates to ERISA preemption. HIPAA's preemption provisions effectively operate as a "floor," establishing a minimum federal standard for the imposition of pre-existing condition coverage exclusions.¹³⁹ All state laws, specifically state insurance laws, with requirements less stringent than HIPAA's minimum federal standard, are preempted.¹⁴⁰ The states remain free, however, to establish more stringent standards for health insurance issuers subject to their jurisdiction.¹⁴¹

HIPAA's approach to preemption, preserving more favorable state insurance laws while preempting less favorable ones, can be criticized for being contrary to one of ERISA's original legislative reform objectives: to provide uniformity of plan administration by preempting multiple and possibly inconsistent state laws for plans operating in more than one state.¹⁴² Consistent with this objective, Congress could have preempted all state insurance laws related to HIPAA's requirements, thus leaving HIPAA as the sole federal standard. As originally enacted and amended, however, ERISA involves a balancing of competing interests.¹⁴³ In the case of HIPAA, one of ERISA's legislative purposes, the protection of plan participants,¹⁴⁴ apparently won out over the competing goal of ensuring simplicity of plan administration.

137. See *id.* § 1191(b)(1).

138. See *id.* § 1191(a)(1), (b)(1).

139. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,913 (1997).

140. See 29 U.S.C.A. § 1191(a)-(b).

141. See *id.*

142. See *supra* note 39 and accompanying text.

143. See *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). The Court explained, [C]ourts may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.

Id. at 1070; see also H.R. REP. NO. 93-533, at 1 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4639 ("The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans.").

144. See H.R. REP. NO. 93-533, at 1, reprinted in 1974 U.S.C.C.A.N. at 4639.

Moreover, the danger to ERISA's uniformity of plan administration objective may be illusory. Prior to the enactment of HIPAA, insured plans operating in more than one state already were being administered to meet the respective insurance laws of each state. For insured plans, HIPAA actually provides a measure of administrative relief by preempting state insurance laws with requirements less stringent than those of HIPAA and substituting a baseline federal standard.¹⁴⁵ Self-insured plans, which previously operated with no standards, are now subject to a single minimum standard—HIPAA's federal requirements.¹⁴⁶

D. Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996, signed into law on September 26, 1996, amends part 7 of Title I of ERISA, previously created by HIPAA, to establish minimum federal standards for maternity hospital benefits offered by private health care plans.¹⁴⁷ These new federal requirements, which are effective for plan years beginning on or after January 1, 1998,¹⁴⁸ apply to any private health care plan, whether insured or uninsured, that has at least two participants who are current employees.¹⁴⁹

Congress enacted NMHPA in response to the perception, held by both physicians and the public, that insurers and health care plans were limiting the duration of plan benefit coverage for postpartum hospital care as a cost-saving measure at the risk of the safety of mothers and newborns.¹⁵⁰ Prior to the enactment of NMHPA, twenty-eight states had adopted state insurance laws establishing minimum post-partum hospital care coverage for mothers and newborns.¹⁵¹ These state laws were of only limited effectiveness, however, because not all states had adopted such laws, and self-insured private health care plans were not subject to these laws by virtue of ERISA preemption.¹⁵²

NMHPA does not require private health care plans to provide maternity benefits.¹⁵³ Rather, the law requires that if a plan provides maternity hospital care benefits, such benefits must meet NMHPA's minimum duration

145. See *supra* notes 139-40.

146. 29 U.S.C.A. § 1191(a)-(b).

147. See Pub. L. No. 104-204, §§ 601-606, 110 Stat. 2935, 2935-44 (codified in scattered sections of 29 U.S.C.A. & 42 U.S.C.A.).

148. See *id.* § 603(c), 110 Stat. at 2938.

149. See 29 U.S.C.A. § 1191a(a).

150. S. REP. NO. 104-326, at 2 (1996).

151. *Id.*

152. *Id.* at 2-3.

153. See 29 U.S.C.A. § 1185(c)(2).

of hospital stay requirements.¹⁵⁴ NMHPA's standards are based on medical practice guidelines developed jointly by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).¹⁵⁵ For a normal vaginal delivery, the minimum hospital stay is set at forty-eight hours.¹⁵⁶ The minimum hospital stay for birth by caesarean section is ninety-six hours.¹⁵⁷ The attending health care provider may, after consultation with the mother, discharge the mother and her newborn child prior to the expiration of the minimum stay requirements.¹⁵⁸ Private health care plans and health insurance issuers are prohibited from providing group financial incentives to mothers to encourage them to accept less than the minimum hospital stay, from penalizing physicians when patients utilize the minimum hospital stay, or from providing incentives to physicians to induce their patients to accept less than the minimum hospital stay.¹⁵⁹

In enacting NMHPA's requirements, Congress recognized it was breaking new legislative ground.¹⁶⁰ The medical community, long opposed to congressional legislation impacting physicians' clinical decision-making, was "virtually unanimous" in its support of NMHPA as a means of insulating doctors from pressure by insurers and health plans for the early discharge of maternity patients.¹⁶¹ Although medical studies on the adverse effects of early discharge had proven inconclusive, Congress admittedly erred on the side of caution in adopting NMHPA's minimum duration post-partum hospital stay requirements based on the ACOG/AAP medical practice guidelines.¹⁶²

NMHPA's preemption provisions are modeled after the new approach to state law preemption used by Congress in HIPAA.¹⁶³ As with HIPAA, NMHPA's amendments to ERISA preserve state insurance laws which are more favorable to covered individuals.¹⁶⁴ Likewise, NMHPA's requirements are enforced through COBRA-type tax penalties and civil enforcement actions pursuant to ERISA.¹⁶⁵

154. *See id.* § 1185(a).

155. *See* S. REP. NO. 104-326, at 2-7.

156. *See* 29 U.S.C.A. § 1185(a)(1)(A)(i).

157. *See id.* § 1185(a)(1)(A)(ii).

158. *See id.* § 1185(a)(2).

159. *See id.* § 1185(b).

160. *See* S. REP. NO. 104-326, at 6.

161. *See id.* at 7.

162. *See id.* at 4-5 (scientific studies on early discharge inconclusive); *see also id.* at 20-21 (additional views of Sen. Jeffords).

163. *See* discussion *supra* Part II.C.

164. *See* 29 U.S.C.A. § 1185(f).

165. *See supra* notes 124, 126 and accompanying text.

E. Mental Health Parity Act of 1996

The original Senate version of HIPAA contained a provision that broadly prohibited any group health plan or insurer offering group or individual health coverage "from imposing treatment limitations or financial requirements on the coverage of mental health services if similar requirements are not imposed on coverage for services for other conditions."¹⁶⁶ The House version of HIPAA, however, did not require "parity" for mental health benefits.¹⁶⁷ The Senate's mental health parity provision was dropped as part of the Joint Conference Committee agreement reconciling the House and Senate versions of HIPAA.¹⁶⁸

Weeks later, mental health parity legislation reappeared in Congress, but in a much more limited form.¹⁶⁹ As enacted, the Mental Health Parity Act amends part 7 of Title I of ERISA to prohibit any group health plan that provides both medical and mental health benefits from imposing lesser aggregate lifetime or annual limits for mental health benefits than for medical care benefits.¹⁷⁰ MHPA's requirements exempt small employers¹⁷¹ and MHPA's parity requirements expressly do not apply to treatment for substance abuse or chemical dependency.¹⁷² Congress also included a sunset provision in MHPA, causing its requirements to expire on September 30, 2001.¹⁷³ Like HIPAA and NMHPA, MHPA's requirements are enforced through COBRA-type tax penalties and civil enforcement actions pursuant to ERISA.¹⁷⁴

MHPA's parity requirements can be easily circumvented by plans or insurers interested in limiting participants' usage of mental health related services because group health plans are not required to provide any mental

166. See H.R. CONF. REP. NO. 104-736, at 238 (1996), *reprinted in* 1996 U.S.C.C.A.-N. 1990, 2051.

167. See *id.*

168. See *id.*

169. See Pub. L. No. 104-204, § 702, 110 Stat. 2944-47 (codified in scattered sections of 29 U.S.C.A. & 42 U.S.C.A.).

170. 29 U.S.C.A. § 1185a(a) (West Supp. 1997). The MHPA is effective for plan years beginning on or after January 1, 1998. See Pub. L. No. 104-204, § 702(c), 110 Stat. at 2947.

171. See 29 U.S.C.A. § 1185a(c)(1) (West Supp. 1997). A small employer is defined as an employer who, with respect to a calendar year and a plan year, employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. See *id.* § 1185a(c)(1)(B).

172. See *id.* § 1185a(e)(4).

173. See *id.* § 1185a(f).

174. See *supra* notes 124, 126 and accompanying text.

health benefits.¹⁷⁵ Thus, for self-insured plans, plan sponsors who want to avoid MHPA's requirements may simply eliminate all mental health benefits from the plan.¹⁷⁶ Alternatively, a plan may restrict mental health benefits other than aggregate or annual limits which are designed to deter plan participants from utilizing mental health services.¹⁷⁷ Such restrictions might include limits on the number of visits or days of in-patient hospital coverage, higher deductibles, or more stringent requirements relating to medical necessity.¹⁷⁸ Moreover, if the costs of the plan increase by at least one percent as a result of the application of MHPA's parity requirements, the plan is exempted from MHPA's parity requirements in future years.¹⁷⁹

F. A New Role for ERISA in the Regulation of Private Health Care Plans?

HIPAA and its related legislation signal a possible new role for ERISA in future federal health care reform initiatives. Future federal reforms are likely to target selected, discrete areas rather than attempting comprehensive reforms. These targeted legislative reforms are likely to be addressed first at the state level through insurance law mandates for certain types of benefits. Once a critical mass of states has accumulated experience in a particular benefit area, Congress is likely to follow by "federalizing" the benefit as an ERISA requirement applicable to all private health care plans, insured and self-insured alike.

HIPAA and its related legislation also signal a new congressional approach to ERISA preemption of state laws in those targeted areas where Congress creates federal coverage and benefits requirements for private health care plans under ERISA. As new federal requirements for private health care plans are enacted through Title I, federal preemption is likely to operate as a floor, preempting state laws that fall below the new minimum federal requirements. State laws providing greater protections and benefits than ERISA's minimum federal requirements are likely to be preserved. Thus, in the future, ERISA preemption of state laws may operate to create a set of minimum national standards for all private health care plans, while

175. See 29 U.S.C.A. § 1185a(b)(1).

176. See *id.* § 1185a(b)(2). Such action apparently would not violate the ADA. See generally EEOC Interim Enforcement Guide, *supra* note 132. Insured plans may be subject to state insurance law mandated health care benefits, which are not preempted by the MHPA's requirements. See 29 U.S.C.A. § 1191(a)(2) (West Supp. 1997); 29 U.S.C. § 1144(b)(2)(A) (1994); see, e.g., *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

177. See 29 U.S.C.A. § 1185a(b)(2).

178. See *id.*

179. See *id.* § 1185a(c)(2).

at the same time permitting the states to provide still greater benefits and protections for participants in insured private health care plans.

III. FUTURE IMPLICATIONS: SOME OBSERVATIONS AND COMMENTS

HIPAA and its related legislation indicate that ERISA is likely to be the legislative vehicle of choice for Congress's future health care reform initiatives. The majority of Americans under age sixty-five with private health care insurance have that coverage through an employment-based health care plan.¹⁸⁰ ERISA is the primary federal law regulating employment-based private health care plans. Consequently, ERISA is the most obvious and most convenient mechanism for Congress to enact future federal health care reforms.

Part II of this article envisions a future scenario in which Congress enacts health care reform by targeting selected, discrete areas for ERISA-mandated private health care plan coverage and benefits. A discussion of the merits of this targeted legislative approach to health care reform (a pejorative "ad hoc" approach or a prudent "incremental reform" approach, depending on one's point of view) is beyond the scope of this article. Consistent with the theme of this symposium, Part III of this article concludes by identifying some of the emerging issues raised by a targeted reform approach for the future role of ERISA in the regulation of private health care plans.

Future attempts at health care reform through ERISA are likely to conflict with the voluntary nature of employment-based health care plans. This conflict, although mitigated somewhat by "targeted" reforms, nevertheless is likely to grow in significance as such reforms multiply into cumulative requirements. ERISA does not require an employer to sponsor a health care plan for its employees.¹⁸¹ ERISA mandates that if the plan sponsor chooses to offer a health care plan to employees, the plan must meet Title I requirements for the protection of plan participants.¹⁸² Inherently, the objective of protecting plan participants is in tension with the competing concern that ERISA's requirements should not be so burdensome that employers will choose not to sponsor employee benefit plans.¹⁸³ NMHPA and MHPA implicitly recognize and potentially reconcile this fundamental conflict in that they do not require private health care plans to offer maternity or mental health benefits¹⁸⁴ (although, for insured plans, these benefits may be mandated by state insurance laws). Rather, if these types of benefits are offered, the plan's benefits must at least meet the new

180. See *supra* note 6.

181. See generally *supra* note 143 and accompanying text.

182. See discussion *supra* Part II.

183. See *supra* note 143.

184. See 29 U.S.C.A. §§ 1185(c)(2), 1185a(b)(1).

minimum federal requirements.¹⁸⁵ Thus, at least with respect to self-insured plans, the decision whether to offer the benefits at all is left up to the plan sponsor.

For some benefits, such as maternity hospital care benefits, this "voluntary" choice on the part of the self-insured plan sponsor may be illusory as a practical matter due to employee demand for the particular benefit. For other types of benefits, such as mental health care benefits, the plan sponsor may, having been given the option, simply cease to offer the benefit under the plan.

As ERISA moves into the next century, one of the most controversial and as yet unresolved issues of health care reform is the potential federal regulation of private health care plan premium costs. HIPAA and its related legislation follow the OBRA financing approach, leaving it to the plan sponsor (and, in the case of insured plans, the insurance issuer) to determine the increased cost of federal benefit requirements and how much of that increased cost will be allocated to the plan participants. HIPAA implicitly rejects the COBRA financing approach by prohibiting plan sponsors from charging higher premiums only to those individuals who are more likely to use the benefits offered under the plan because they have a pre-existing condition or are identified as having a health-related factor.¹⁸⁶

It remains to be seen whether, if left unregulated at the federal level, premium costs will increase to such an extent as to significantly reduce private health care plan coverage.¹⁸⁷ It would be ironic indeed if the reforms made by HIPAA and its related legislation, which were the byproduct of the Clinton Administration's ambitious attempt to create universal health care coverage, in fact result in a decrease in coverage due to increased premium costs.

As discussed in Part II, HIPAA and its related legislation signal a possible new congressional approach to ERISA preemption. One consequence of this new approach will be the need for a bright-line definition, at the federal level, of what constitutes an "insured" plan subject to state insurance law regulation and mandated benefit requirements. The *AMS* case¹⁸⁸ aptly illustrates that as the private sector continues to experiment with new plan financing arrangements and insurance products, the line between insured and self-insured plans, and thus the line between state and federal regulation, will become increasingly blurred. A federal solution will be required to draw this line.

185. See discussion *supra* Part II.D-E.

186. See *supra* text accompanying notes 82-83, 119.

187. See Interim Rules for Health Insurance Portability for Group Health Plans, 62 Fed. Reg. 16,894, 16,911-12 (1997) (describing Congressional Budget Office estimates of the direct cost to the private sector of compliance with HIPAA's requirements, but noting that these cost estimates are "subject to considerable uncertainty").

188. 111 F.3d 358 (4th Cir. 1997) (discussed *supra* Part I.C.).

Finally, the future appears to hold a greatly expanded role for the federal courts in the enforcement of new Title I rights for participants in private health care plans. The new Title I rights created by HIPAA and its related legislation are enforceable in federal court as private causes of action by individual plan participants via ERISA's civil enforcement scheme.¹⁸⁹ Although the most blatant violations are likely to be addressed by state insurance commissioners or the Secretary of Labor, resources available for enforcement at the state and federal levels are necessarily limited. With the potential for class actions and ERISA's provision for the award of attorney's fees and costs,¹⁹⁰ individual plaintiffs are likely to play a significant enforcement role. Their claims will most likely be heard in the federal courts.¹⁹¹

189. See *supra* notes 126 and accompanying text.

190. See 29 U.S.C. § 1132(g) (1994).

191. See *id.* § 1132(e)(1) (granting the federal courts exclusive jurisdiction over ERISA section 502(a)(2)-(a)(3) claims, as provided in 29 U.S.C. § 1132(a)(2)-(3), and concurrent jurisdiction with the state courts for denial of plan benefit claims brought pursuant to ERISA § 502(a)(1)(B), as provided in 29 U.S.C. § 1132(a)(1)(B)).